

Readiness to Change in PTSD Treatment 4 Written Video Transcript

Okay. What I'd like to is stop again for questions. I'm at a natural break here. Any thoughts or questions at this point? [00:00.20.00] Thank you. Alright. No questions? Alright. Well, what do you with all this stuff? How do you actually make it useful for the patients? Let me tell you how [00:00.40.00] we have attempted to make it useful for the patients. Two things I'm going to talk to you about today. General approach to working with patient. So, separate from the PTSD motivation enhancement group, but just some general approaches you can use that will help move people up the stages of change. [00:01.00.00] Then I'll talk about the ME group. All right. So, response style—your response style, not the patient's—your response style and tactics that are going help people move up the stages of change. It's usually presented as a wheel or more Buddhist like also, but I'm a little more concrete [00:01.20.00] so I have to have sort of ladder model. And that's why I'm presenting it that way. Okay? So general approach is—and this is all from Bill Miller—you've got to use reflective listening and empathy. Builds therapeutic relationship, patient feels understood. You get more done when the patient—when you say to a patient, [00:01.40.00] "Tell more about that," or "It sounds like you're feeling this way because of what happened." The patient will then keep talking to you. Very important. Always objective, nonconfrontational, at least in the classic style. I'm going to tell you about another way. Avoid argumentation, which I've tried to be good. I've been abstinent from arguing [00:02.00.00] with patients for quite a while now. (Fred Gusman) used to say, "We're supposed to be smarter than the patients." And after I would argue with him, he'd pull me aside, you know—not that our IQs are high, we're supposed to know a little more, right. Okay. Roll with resistance. Go with it. Respond to it, don't just shut it off. [00:02.20.00] Always give the patients credit for movement, whether it's in starting to acknowledge a problem, if they change in general. You always want to say patient, you know—patients come to us, "Oh thank you, so great," and all that. Always say 100% of the credit, you. Because we do what we do all the time and what percent of the patients respond to it? [00:02.40.00] Some do, some don't. So a patient responds, well you have to give them the credit. And the other thing here—and what Jean has raised earlier—really that I don't have on the slide, you've got to have the atmosphere safe for patients to say, "You know what, I really don't think I think [00:03.00.00] about the world in a wrong way. I think you've missed it." I was talking to Karen Thompson, the director of the PTSD clinic in New Orleans the other day. And she said that (when she was in a) motivation group someone had said to her—let me see if I can get that exact quote. [00:03.20.00] The patient had said that Vietnam had woken him up to reality and that he feels the rest of the world is in a dream land, in a dream world. You know, there's some philosophical issues about that. And certainly we're facing a lot of them in terms of our own views of safety [00:03.40.00] from what happened two weeks ago. Right? But think about how the world looks to these patients when they're this convinced. Okay. And I think we have to make it safe for them to express more ambivalence about their symptoms. Okay. [00:04.00.00] Now,



what I want to emphasize is that you can do this stuff and not let patients walk all over you. All right? There's a way to do this and still be firm, limit setting, prevent people from acting out, boot people when they need to go, all right, and [00:04.20.00] set limits on disruptiveness. The best type of confrontation is making a clear comparison when someone's having a problem either with program rules or at home on pass, a clear comparison between what they want out of life and the way they're acting. Someone comes in and says, "I want to get along with people. I want to be able to stand in the Walmart [00:04.40.00] line for more than two minutes. I want to have a decent conversation with my boss." And if they're arguing with their roommates and you know, going crazy on the staff and having trouble, before you kick them out say, "Look let's just talk about these two things. Because your behavior is inconsistent with what you told us what your goals are." [00:05.00.00] I think that's true confrontation. I think it's possible to use this model and still make it clear to patients, you know, don't mistake kindness for weakness. Time to kick patients out, discharge them. Time to say, "If you do this again, you're gone." Maybe not quite like that, right, but. [00:05.20.00] There's a way to do this. There's a way to set limits on disruptiveness. And what we've had to do in our group, just like every other group—let me tell you a little more how we try to model this is, nice ways of telling a patient to shut up and sit down. We've got to get on with this group. And there's nice ways to do it, where you do it, [00:05.40.00] where you get that patient to stop whatever disruptive behavior is going on. So this is not, this model is not inconsistent with limit setting. Now I'm going to tell you a little bit about the PTSD Motivation Enhancement Group. This is a brief therapy [00:06.00.00] intervention that we worked on here at Menlo, I've been doing in New Orleans also. The rationale for this group is that post-treatment return of symptoms—very important that I'm framing this [00:06.20.00] as you've been in treatment, okay now you're out of treatment. How do you go back to having problems? Because even the (Rosenheck and Fontana) Study showed patients do very well in treatment. When they're in treatment they look real good, they do very well. And what happens when they return to symptoms? So obviously many of you are hearing a relapse [00:06.40.00] prevention model here. My bias anyway. So, why do people go back to have problems? It's not because treatment's bad. It's not because they're unfixable for any reason whether it's the length of the disorder or some sort of biological change, all right, or attitudinal. But there's another possibility [00:07.00.00] why people do not get better after treatment and that it that unacknowledged problems lead to a return to old coping styles. What we call in the PTSD Motivation Enhancement Group getting blindsided, where an unacknowledged problem starts a slow spiral back [00:07.20.00] through a return of symptoms. For example, if you really don't believe that your trust levels are a problem in terms of how suspicious you are and you don't get close to anybody and you don't trust anybody and you're always watching people and you go back out after treatment, even if you worked on your anger and all kinds of other things, what's the first thing [00:07.40.00] you're going to do? Well you're probably not going to hang around with a lot of people. Because you may not like the. Of course the flip side tends to be, which is a shock for a lot of patients and ourselves too sometimes, is well they don't like you either. You're not that pleasant to be around when you're like that. So they isolate more. Hypervigilance starts to kick in, [00:08.00.00] maybe substance abuse. And then that's



when Vietnam starts to come back or combat trauma, other things also. And I think this spiral can start with different things. What I'm trying to present to you, I hope I'm being clear, that it probably starts with something that you don't think is a problem. And this is how we explain it to the patients. [00:08.20.00] So, the way I'm talking to you is how I talk to the patients when we're doing the rationale part of the group. Of course the goal of the group is to raise motivation to change PTSD symptoms and related problems or to bump up people at a stage of change. This is mostly about precontemplation and contemplation. Okay? [00:08.40.00] Increase awareness of the need to change, decrease ambivalence about the need to change. Now the long term goal here—now this we have not shown—is to increase engagement in treatment. What you hope is if people become a little more convinced they've got a problem those groups start to [00:09.00.00] look a little more attractive. And of course what we hope for ultimately is that patients use these skills when they're under stress and when the symptoms come back because they know their problem's flaring up. Remember I was talking about that before. I hope you see some of those connections. All right, what is the group, brief [00:09.20.00] therapy group, seven sessions. I've done it shorter, I've done it longer. Objective and nonconfrontational. We don't confront the patients in the old style. When they say things that—part of this of course you want—you got to bite your tongue. I worked with a patient who had, you know, ankle bracelet [00:09.40.00] because he'd had so many DUI's, couldn't even go out of the house. He'd be like, "You know, I don't know if this is really a problem for me. I think I can probably control it and you know." Coming from this model, I mean I believe in this, I believe in those sort of cognitive conceptualizations. But there are times when you want to say, "Geez, [00:10.00.00] are you kidding me?" But of course that, you don't—we don't say that anymore, right? All right. We modified basic motivational interviewing, Miller techniques, for group format. It was not done so much when we first started doing this but you're seeing this a lot more, the modified for group. [00:10.20.00] Now, let me tell you the sequence and then I'm going to tell you the modules. This is session one. This would be sort of the classic seven session way of doing this. Where you have first session, rationale and might have. Okay? Thank you. [00:10.40.00] So, we talk to patients about, you know, what is the motivation enhancement group? What is it about? Why are you here. We're very clear, we spend a lot of time on that. The second part of that group is getting people to list—the patients to list their might have. Okay. [00:11.00.00] The second two groups are one module, which we call comparison to the average guy. This tends to be our wildest group for reasons you can imagine. I'll tell you a little bit about trying to get a group of combat veterans to see, you know, to look at maybe what the average guy's doing. And from my—what I told you earlier and I think from of your experience also from what I'm seeing [00:11.20.00] from your reaction is that you understand what this, what this is about. So it's a norm comparison module. Then we do pros and cons for two sessions and then what we call road blocks, which I'll talk about. Now, I really like doing this with rolling admissions. When I first started doing this group I didn't like the rolling admissions context [00:11.40.00] but I think that that sort of a senior / junior culture in the groups is very powerful. And a lot of research shows that peer therapy is more powerful than therapist's therapy. So, if you can get peers, both for kids and adults—and the more you can involve peers in doing interventions I think the better off you'll be.



[00:12.00.00] Just because when guys come into treatment they tend to be distracted, foggy for a lot of reasons, when we do rolling admissions we have them go through seven groups so that they repeat the first one. So, the seventh group is a repeat of the first one they showed up in, which for most guys seems brand new. They don't even remember they were there for that, so. Something I'm [00:12.20.00] not going to focus on too much, for every group—I try to do this as behaviorally as possible—every group the first half is a replay of what the rationale is as well as we go over the might haves. Okay, so a lot of rehearsal, a lot of rehearsal which our guys need, right, the combat veterans [00:12.40.00] need. So, we try to make it very clear about what they're supposed to be doing in the group.

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